		FOR OHF USE					

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028753

Facility Name: Glencrest Nursing Rehabilitation Center

Address: 2451 West Touhy Avenue (Number) Chicago (City) 60645 (Zip Code)

County: Cook

Telephone Number: (773) 338-6800 **Fax #** (773) 338-1166

IDPA ID Number: 363294202001

Date of Initial License for Current Owners: 06/01/1984

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Altschuler, Melvoin and Glasser LLP

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed) _____ (Date)
	(Type or Print Name) _____
	(Title) _____
Paid Preparer	(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title) _____
	(Firm Name & Address) Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800 Chicago, IL 60606-3392
	(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	154	Skilled (SNF)	154	56,364	1
2		Skilled Pediatric (SNF/PED)			2
3	158	Intermediate (ICF)	158	57,828	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	312	TOTALS	312	114,192	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	38,747	1,782	6,254	46,783	8
9	SNF/PED					9
10	ICF	46,907	3,265	0	50,172	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	85,654	5,047	6,254	96,955	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.91%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/84

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/14/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 36 and days of care provided 5622

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 10/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	339,885	74,662	35,360	449,907		449,907	0	449,907			1
2	Food Purchase		668,316		668,316	(30,928)	637,388	(51,460)	585,928			2
3	Housekeeping	265,634	79,224		344,858		344,858	0	344,858			3
4	Laundry	110,592	56,669		167,261		167,261	0	167,261			4
5	Heat and Other Utilities			169,678	169,678		169,678	8,626	178,304			5
6	Maintenance	111,665	34,904	99,320	245,889		245,889	41,180	287,069			6
7	Other (specify):*							0				7
8	TOTAL General Services	827,776	913,775	304,358	2,045,909	(30,928)	2,014,981	(1,654)	2,013,327			8
	B. Health Care and Programs											
9	Medical Director			44,000	44,000		44,000	0	44,000			9
10	Nursing and Medical Records	2,867,486	358,913	205,758	3,432,157	(13,750)	3,418,407	(122,517)	3,295,890			10
10a	Therapy		797	167,006	167,803		167,803	0	167,803			10a
11	Activities	141,641	6,517	1,221	149,379		149,379	0	149,379			11
12	Social Services	52,041		3,753	55,794		55,794	0	55,794			12
13	Nurse Aide Training					2,654	2,654	0	2,654			13
14	Program Transportation			490	490		490	0	490			14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	3,061,168	366,227	422,228	3,849,623	(11,096)	3,838,527	(122,517)	3,716,010			16
	C. General Administration											
17	Administrative	224,784		1,386,711	1,611,495		1,611,495	(1,386,711)	224,784			17
18	Directors Fees							0				18
19	Professional Services			112,903	112,903	(11,037)	101,866	5,498	107,364			19
20	Dues, Fees, Subscriptions & Promotions			25,128	25,128		25,128	1,978	27,106			20
21	Clerical & General Office Expenses	395,672	62,827	49,163	507,662		507,662	68,536	576,198			21
22	Employee Benefits & Payroll Taxes			630,109	630,109	30,928	661,037	60,999	722,036			22
23	Inservice Training & Education			3,916	3,916	(1,454)	2,462	711	3,173			23
24	Travel and Seminar							1,781	1,781			24
25	Other Admin. Staff Transportation			28,519	28,519		28,519	2,107	30,626			25
26	Insurance-Prop.Liab.Malpractice			91,785	91,785		91,785	2,407	94,192			26
27	Other (specify):*							0				27
28	TOTAL General Administration	620,456	62,827	2,328,234	3,011,517	18,437	3,029,954	(1,242,694)	1,787,260			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,509,400	1,342,829	3,054,820	8,907,049	(23,587)	8,883,462	(1,366,865)	7,516,597			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000 SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			123,455	123,455		123,455	249,183	372,638			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			93	93		93	175,765	175,858			32
33	Real Estate Taxes					9,837	9,837	310,339	320,176			33
34	Rent-Facility & Grounds			2,276,372	2,276,372		2,276,372	(2,273,372)	3,000			34
35	Rent-Equipment & Vehicles			29,756	29,756		29,756	10,727	40,483			35
36	Other (specify):*							0				36
37	**TOTAL Ownership**			2,429,676	2,429,676	9,837	2,439,513	(1,527,358)	912,155			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		138,927	13,534	152,461	13,750	166,211	0	166,211			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			170,820	170,820		170,820	0	170,820			42
43	Other (specify):* Non-Allowable			296,866	296,866		296,866	(296,866)				43
44	**TOTAL Special Cost Centers**		138,927	481,220	620,147	13,750	633,897	(296,866)	337,031			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,509,400	1,481,756	5,965,716	11,956,872	0	11,956,872	(3,191,089)	8,765,783			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Print Preview

SEE ACCOUNTANTS' COMPILATION REPORT

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(312,618)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(931)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(4,028)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(203,148)	43		24
25	Fund Raising, Advertising and Promotional	(25,279)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(64,329)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(7,376)	43		28
29	Other-Attach Schedule See Attached Schedule F	(176,910)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (794,619)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(2,396,470)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (2,396,470)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (3,191,089)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program	X		13,750	Ln10,Co 3	44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			$ 13,750		47

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Detail lines 29 and 35 of Page 9 starting in B44. DO NOT DRAG AND DROP CELLS.

The amounts in column F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page-9A**

Facility Name: Gibson City Rehabilitation Center

Provider No. 0828743

Report Period Beginning: 1/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V Line	Adj. Summary
The information listed in B13 thru G43 is from Page S.				
1 Day Care	0	0	Line 1	0
2 Other Care for Outpatients	0	0	Line 2	(51,460)
3 Governmental Sponsored Special Programs	0	0	Line 3	0
4 Non-Patient Meals	0	0	Line 4	0
5 Telephone, TV & Radio in Resident Rooms	0	0	Line 5	0
6 Rented Facility Space	0	0	Line 6	20,400
7 Sale of Supplies to Non-Patients	0	0	Line 7	0
8 Laundry for Non-Patients	0	0	Line 8	(29,060)
9 Non-Straight-line Depreciation	0	0	Line 9	0
10 Interest and Other Investment Income	(312,410)	32	Line 10	(122,017)
11 Discounts, Allowances, Rebates & Refunds	0	0	Line 10a	0
12 Non-Working Officer's or Owner's Salary	0	0	Line 11	0
13 Sales Tax	(933)	43	Line 12	0
14 Non-Care Related Interest	0	0	Line 13	0
15 Non-Care Related Owner's Transactions	0	0	Line 14	0
16 Personal Expenses (Including Transportation)	0	0	Line 15	0
17 Non-Care Related Fees	0	0	Line 16	(125,419)
18 Fines and Penalties	0	0	Line 17	0
19 Entertainment	0	0	Line 18	0
20 Contributions	(4,028)	43	Line 19	(27,254)
21 Owner or Key Man Insurance	0	0	Line 20	0
22 Special Legal Fees & Legal Retainers	0	0	Line 21	0
23 Life Insurance Insurance for Individuals	0	0	Line 22	0
24 Bad Debt	(203,148)	43	Line 23	0
25 Fund Raising, Advertising and Promotional	(25,270)	43	Line 24	0
26 Income & IL Personal Property Replacement Taxes	(44,329)	43	Line 25	0
27 Nurse Aide Training for Non-Employees	0	0	Line 26	0
28 Yellow Page Advertising	(7,376)	43	Line 27	0
29 Non-Paid Workers	0	0	Line 28	(27,254)
30 Donated Goods	0	0	Line 29	(175,673)
31 Amortization Expense	0	0	Line 30	0
32 Adj. Management Comp. Medical Supplies "A" To Cost	(74,497)	10	Line 31	0
33 Adj. Management Comp. Medical Supplies "Other" To Cost	(48,020)	10	Line 32	(212,814)
34 Adj. Management Comp. Food To Cost	(91,460)	2	Line 33	0
35 Non-allowable Professional Fees	(27,234)	19	Line 34	0
36 Refer 2000 Painting and Decorating	(17,664)	6	Line 35	0
37 Amortization of Current Year Deferred Maintenance	43,869	6	Line 36	0
38 Patients Clothing	(1,100)	43	Line 37	(212,814)
39			Line 38	0
40			Line 39	0
41			Line 40	0
42			Line 41	0
43			Line 42	0
44			Line 43	(368,185)
45			Line 44	(265,140)
46			Line 45	754,811

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure to include highlighted rows 0 thru G.**
2. **Push the Print Other Adjustments button.**

Print Other Adjustments

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(51,460)	0	0	0	0	0	0	0	0	0	0	(51,460)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	8,626	0	0	0	0	0	0	0	0	8,626	5
6	Maintenance	25,405	0	15,775	0	0	0	0	0	0	0	0	41,180	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(26,055)	0	24,401	0	0	0	0	0	0	0	0	(1,654)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(122,517)	0	0	0	0	0	0	0	0	0	0	(122,517)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(122,517)	0	0	0	0	0	0	0	0	0	0	(122,517)	16
	C. General Administration													
17	Administrative	0	0	(324,231)	(1,062,480)	0	0	0	0	0	0	0	(1,386,711)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(27,234)	0	32,732	0	0	0	0	0	0	0	0	5,498	19
20	Fees, Subscriptions & Promotions	0	0	1,978	0	0	0	0	0	0	0	0	1,978	20
21	Clerical & General Office Expenses	0	0	41,645	0	26,891	0	0	0	0	0	0	68,536	21
22	Employee Benefits & Payroll Taxes	0	0	60,999	0	0	0	0	0	0	0	0	60,999	22
23	Inservice Training & Education	0	0	711	0	0	0	0	0	0	0	0	711	23
24	Travel and Seminar	0	0	1,781	0	0	0	0	0	0	0	0	1,781	24
25	Other Admin. Staff Transportation	0	0	2,107	0	0	0	0	0	0	0	0	2,107	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,407	0	0	0	0	0	0	0	0	2,407	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(27,234)	0	(179,871)	(1,062,480)	26,891	0	0	0	0	0	0	(1,242,694)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(175,806)	0	(155,470)	(1,062,480)	26,891	0	0	0	0	0	0	(1,366,865)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	33,931	0	215,252	0	0	0	0	0	0	249,183	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(312,618)	0	36,501	0	451,882	0	0	0	0	0	0	175,765	32
33	Real Estate Taxes	0	0	12,958	0	297,381	0	0	0	0	0	0	310,339	33
34	Rent-Facility & Grounds	0	0	0	0	(2,273,372)	0	0	0	0	0	0	(2,273,372)	34
35	Rent-Equipment & Vehicles	0	0	10,727	0	0	0	0	0	0	0	0	10,727	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(312,618)	0	94,117	0	(1,308,857)	0	0	0	0	0	0	(1,527,358)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(306,195)	0	0	0	9,329	0	0	0	0	0	0	(296,866)	43
44	**TOTAL Special Cost Centers**	(306,195)	0	0	0	9,329	0	0	0	0	0	0	(296,866)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(794,619)	0	(61,353)	(1,062,480)	(1,272,637)	0	0	0	0	0	0	(3,191,089)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE ACCOUNTANTS' COMPILATION REPORT

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT
FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number: Glenwood Nursing Rehabilitation Center # 0920752 Report Period Beginning: 1/01/2008 Ending: 12/31/2008

VII. RELATED PARTIES

Show Pgs 6A thru 6D | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Sidney Glesner	80.00 %	Glen Oaks Nursing & Rehabilitation Centre,Ltd	Northbrook	SEE ATTACHED SCHEDULE A		
Barry Ray	20.00 %	Glenbridge Nursing & Rehabilitation Centre,Ltd	Niles			
		Glen Elston Nursing & Rehabilitation Centre,Ltd	Chicago			
		Glenbiden Nursing & Rehabilitation Centre,Ltd	Rickeson Park			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization: Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
1	V		$		%	$	$	1	
2	V	Total from Page 6A	324,231	Glen Health and Home Management, Inc.	A	263,878	(61,353)	2	-61353
3	V				%	-	-	3	
4	V	Total from Page 6B	1,062,480	Glenbar Management Company, Ltd.	B	-	(1,062,480)	4	-1062480
5	V				%	-	-	5	
6	V	Total from Page 6C	2,273,273	Glenf.test Real Estate & Development, L.L.C.	C	1,000,735	(1,272,537)	6	-1272537
7	V				%	-	-	7	
8	V				%	-	-	8	
9	V				%	-	-	9	
10	V				%	-	-	10	
11	V				%	-	-	11	
12	V				%	-	-	12	
13	V				%	-	-	13	
14	Total		$ 3,660,002			$ 1,263,613	$ + (2,396,470)	14	

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPOR

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Preview

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	17	Management Fees	$ 324,231	Glen Health and Home Management, Inc.	A	$	$ (324,231)	15	-324231
16	V	5	Utilities		Glen Health and Home Management, Inc.	A	8,626	8,626	16	8626
17	V	6	Repairs and Maintenance		Glen Health and Home Management, Inc.	A	15,775	15,775	17	15775
18	V	19	Professional Fees		Glen Health and Home Management, Inc.	A	32,732	32,732	18	32732
19	V	20	Licenses, Permits and Inspection		Glen Health and Home Management, Inc.	A	1,978	1,978	19	1978
20	V	21	Clerical		Glen Health and Home Management, Inc.	A	41,645	41,645	20	41645
21	V	22	Employee Benefits and Payroll		Glen Health and Home Management, Inc.	A	60,999	60,999	21	60999
22	V	23	Training and Education		Glen Health and Home Management, Inc.	A	711	711	22	711
23	V	25	Auto Expenses		Glen Health and Home Management, Inc.	A	2,107	2,107	23	2107
24	V	26	Insurance		Glen Health and Home Management, Inc.	A	2,407	2,407	24	2407
25	V	32	Amortization of Mortgage Cost		Glen Health and Home Management, Inc.	A	380	380	25	380
26	V	30	Depreciation		Glen Health and Home Management, Inc.	A	33,931	33,931	26	33931
27	V	32	Interest		Glen Health and Home Management, Inc.	A	36,121	36,121	27	36121
28	V	33	Real Estate Taxes		Glen Health and Home Management, Inc.	A	12,958	12,958	28	12958
29	V	35	Equipment and Vehicle Rental		Glen Health and Home Management, Inc.	A	10,727	10,727	29	10727
30	V	24	Travel		Glen Health and Home Management, Inc.	A	1,781	1,781	30	1781
31	V								31	
32	V								32	
33	V								33	
34	V				A - OWNERSHIP:				34	
35	V				Sidney Glenner - 41.50 %				35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 324,231			$ 262,878	$ * (61,353)	39	

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6B

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Administrative	$ 1,062,480	GlenBar Management Company, Ltd.	B	$	$ (1,062,480)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V				B - OWNERSHIP:				20
21	V				Sidney Glenner - 80.00%				21
22	V				Barry Ray - 20.00 %				22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,062,480			$	$ * (1,062,480)	39

Sum_6B

-1062480

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6C

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6C
15	V	21	Bond Fees	$	GlenCrest Real Estate & Development, L.L.C.	C	$ 21,391	$ 21,391	15	21391
16	V	21	Clerical Expense		GlenCrest Real Estate & Development, L.L.C.	C	5,500	5,500	16	5500
17	V	30	Depreciation		GlenCrest Real Estate & Development, L.L.C.	C	215,252	215,252	17	215252
18	V	32	Interest Income		GlenCrest Real Estate & Development, L.L.C.	C	(59,552)	(59,552)	18	-59552
19	V	33	Real Estate Taxes - Legal		GlenCrest Real Estate & Development, L.L.C.	C	35,889	35,889	19	35889
20	V	33	Real Estate Taxes		GlenCrest Real Estate & Development, L.L.C.	C	261,492	261,492	20	261492
21	V	34	Rental	2,273,372	GlenCrest Real Estate & Development, L.L.C.	C		(2,273,372)	21	-2273372
22	V	43	State Replacement Taxes		GlenCrest Real Estate & Development, L.L.C.	C	9,329	9,329	22	9329
23	V	32	Interest Expense		GlenCrest Real Estate & Development, L.L.C.	C	511,434	511,434	23	511434
24	V								24	
25	V								25	
26	V								26	
27	V				C - OWNERSHIP:				27	
28	V				Sidney Glenner - 80.00 % (constructively)				28	
29	V				Barry Ray - 20.00 %				29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 2,273,372			$ 1,000,735	$ * (1,272,637)	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6D

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$	GlenCrest Real Estate & Development, L.L.C.		$	$	15
16	V				GlenCrest Real Estate & Development, L.L.C.				16
17	V				GlenCrest Real Estate & Development, L.L.C.				17
18	V				GlenCrest Real Estate & Development, L.L.C.				18
19	V				GlenCrest Real Estate & Development, L.L.C.				19
20	V				GlenCrest Real Estate & Development, L.L.C.				20
21	V				GlenCrest Real Estate & Development, L.L.C.				21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V				OWNERSHIP:				27
28	V				Sidney Glenner - 80.00 % (constructively)				28
29	V				Barry Ray - 20.00 %				29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sidney Glenner	President	Administrative	80.00 %	103,815	13	22.00 %	Salary	$ 31,185	Line 17,Col 1	1
2	Barry Ray	Vice President	Administrative	20.00 %	77,861	9	23.00 %	Salary	23,389	Line 17,Col 1	2
3	David Glenner	Vice President	Administrative	0.00 %	57,675	9	23.00 %	Salary	17,325	Line 17,Col 1	3
4											4
5											5
6			See Schedule B								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 71,899		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Glen Health & Home Management, Inc.
Street Address: 5454 West Fargo
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 674-5454
Fax Number: (847) 674-8311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	419,697	5	$ 37,338	$	96,955	$ 8,626	1
2	6	Repairs and Maintenance	Patient Days	419,697	5	68,287		96,955	15,775	2
3	19	Professional Fees	Patient Days	419,697	5	141,688		96,955	32,732	3
4	20	Licenses, Permits and Inspection	Patient Days	419,697	5	8,563		96,955	1,978	4
5	21	Clerical	Patient Days	419,697	5	180,270		96,955	41,645	5
6	22	Employee Benefits and Payroll	Patient Days	419,697	5	264,051		96,955	60,999	6
7	23	Training and Education	Patient Days	419,697	5	3,079		96,955	711	7
8	25	Auto Expenses	Patient Days	419,697	5	9,121		96,955	2,107	8
9	26	Insurance	Patient Days	419,697	5	10,420		96,955	2,407	9
10	30	Depreciation	Patient Days	419,697	5	146,881		96,955	33,931	10
11	32	Interest	Patient Days	419,697	5	156,358		96,955	36,121	11
12	33	Real Estate Taxes	Patient Days	419,697	5	56,094		96,955	12,958	12
13	35	Equipment and Vehicle Rental	Patient Days	419,697	5	46,437		96,955	10,727	13
14	32	Amortization of Mortgage Cost	Patient Days	419,697	5	1,646		96,955	380	14
15	24	Travel	Patient Days	419,697	5	7,709		96,955	1,781	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,137,942	$		$ 262,878	25

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	American National Bank		X	Mortgage	$600,000 annual	1/26/1994	$ 10,000,000	$ 6,500,000	2/15/2024	variable	$ 505,601	1
2	American National Bank		X	Amortization of mortgage costs							5,833	2
3												3
4						Mortgage interest expense allocated from Management Company:						36,501	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 10,000,000	$ 6,500,000			$ 547,935	9
	B. Non-Facility Related*											
10								Interest income offset:			(372,170)	10
11								Miscellaneous interest expense:			93	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (372,077)	14
15	TOTALS (line 9+line14)						$ 10,000,000	$ 6,500,000			$ 175,858	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	367,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	357,695	2
3. Under or (over) accrual (line 2 minus line 1).	$	(9,805)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	367,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	45,726	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 95,703 For 19 94-96 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$	(95,703)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	307,218	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	350,490	8
1996	359,114	9
1997	353,831	10
1998	360,112	11
1999	357,695	12

See Attached Schedule H For Calculation Of 2000 Real Estate Tax Accrual.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**

This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,400 B. General Construction Type: Exterior Brick Frame Multi-story steel Number of Stories Four

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	53,193	1994	$ 524,482	1
2	Allocated from Management Company:			24,200	2
3	TOTALS	53,193		$ 548,682	3

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	312		1994		$ 4,175,048	$	30	$ 104,376	$ 104,376	$ 726,810	4
5											5
6	Mgt Comp:				514,749			10,965	10,965		6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Various Improvements			1984	14,558		10			14,558	9
10	Various Improvements			1985	49,988		10			49,988	10
11	Various Improvements			1986	53,010		10			53,010	11
12	Various Improvements			1987	18,999		10			18,999	12
13	Various Improvements			1988	10,172		10			10,172	13
14	Various Improvements			1989	43,502		10			43,502	14
15	Various Improvements			1990	28,496	447	10	712	265	28,496	15
16	Various Improvements			1991	26,763	202	10	669	467	19,553	16
17	Various Improvements			1992	51,415	903	10	4,423	3,520	32,347	17
18	Various Improvements			1993	32,359	3,236	10	3,236		24,808	18
19	Various Improvements			1994	36,809	3,681	10	3,681		24,539	19
20	Various Improvements			1995	49,197	4,919	10	4,919		27,877	20
21	Security cameras throughout facility with housings/wiring			1995	8,985	899	10	899		4,195	21
22	Call lights in dialysis room			1996	1,191	119	10	119		556	22
23	Second floor custom nurses station, hand rails			1996	24,426	2,443	10	2,443		11,400	23
24	Basement mason work, 2 rooms constructed rehab, room			1996	11,685	1,169	10	1,169		5,454	24
25	Hand rails and wall bumper guards			1996	19,408	1,941	10	1,941		9,058	25
26	Custom wall mounted bookcases			1996	5,510	551	10	551		2,572	26
27	First floor custom nurses station, reconfigure soffit			1996	20,882	2,088	10	2,088		9,744	27
28	Install electrical lines into activity room			1996	1,000	100	10	100		467	28
29	Install counter tops, sink and wood file cabinets			1996	3,700	370	10	370		1,727	29
30	Install four 70 watt high pressure lights over exit signs			1996	1,900	190	10	190		887	30
31	Swag valence in dining rooms			1996	2,342	234	10	234		1,092	31
32	Door locks and fire doors			1996	5,241	524	10	524		1,921	32
33	Electrical outlets and circuits			1997	4,950	495	10	495		1,815	33
34	Elevator frames, doors & other parts			1997	10,626	1,062	10	1,062		3,895	34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 25,573		$ 145,166	$ 119,593	$ 1,129,442	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11	Cabinets and sinks			1997	26,743	2,674	10	2,674		9,806	11
12	Elevator repairs			1997	7,700	770	10	770		2,053	12
13	Furnace repairs			1997	2,321	232	10	232		619	13
14	Chain link fencing			1998	3,000	300	10	300		800	14
15	HVAC system modifications			1998	2,307	231	10	231		615	15
16	Fire alarm system improvements			1998	4,148	415	10	415		1,106	16
17	Exhaust system			1998	4,980	498	10	498		1,328	17
18	HVAC system modifications			1998	2,008	201	10	201		535	18
19	18 access doors			1998	2,824	282	10	282		753	19
20	HVAC system modifications			1998	6,866	687	10	687		1,831	20
21	Fire alarm smoke detectors			1998	12,024	1,202	10	1,202		3,206	21
22	4 smoke/fire dampers			1998	1,235	124	10	124		329	22
23	Roof repairs			1998	5,000	500	10	500		1,333	23
24	Wallpaper			1999	6,529	653	10	653		1,088	24
25	Install handrails and bumpers			1999	11,501	1,150	10	1,150		1,917	25
26	4th floor nurses station-with angled radius corners			1999	7,500	750	10	750		1,250	26
27	4th floor nurses station-with angled radius corners			1999	7,505	751	10	751		1,251	27
28	Carpeting			1999	45,885	4,588	10	4,588		7,648	28
29	Cove base installation			1999	15,738	1,574	10	1,574		2,623	29
30	Install back porch siding and 2 doors			1999	4,000	400	10	400		667	30
31	Install back porch siding and 2 doors			1999	9,270	927	10	927		1,545	31
32	Heavy duty electrohydraulic ADA operator			1999	2,547	255	10	255		424	32
33	Diesel generator			1999	54,879	5,488	10	5,488		9,147	33
34	Emergency generator			1999	111,000	11,100	10	11,100		18,500	34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 35,752		$ 35,752	$	$ 70,374	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Install door alarm system on 4 floors			1999	7,817	782	10	782		1,303	9
10	Wallpaper			1999	5,859	586	10	586		976	10
11	Furnished and installed 2 door restrictors			1998	2,600	260	10	260		433	11
12	Install handrails and bumpers			1999	4,600	460	10	460		767	12
13	Laundry room exhaust			1999	1,922	192	10	192		320	13
14	Furnish and install fire alarm equipment			1999	1,920	192	10	192		320	14
15	Radiator valve repairs			1999	2,359	236	10	236		393	15
16	Install plumbing for whirlpool tub			1999	2,400	240	10	240		400	16
17	Cove base/amtico installation			1999	3,146	315	10	315		524	17
18	Resident room signs & common area signs			1999	2,731	273	10	273		455	18
19	Install resident windows on 4th floor & upholstering			1999	13,284	1,328	10	1,328		2,214	19
20	Handrails, bumpers, accent rails & cove base installation			2000	4,592	230	10	230		230	20
21	Furnish & install mixing valve, vent & water piping			2000	5,731	287	10	287		287	21
22	Complete electrical work for 10 dialysis chairs			2000	4,575	229	10	229		229	22
23	Furnish & install hand sink			2000	2,501	125	10	125		125	23
24	Install locks on 4th floor			2000	4,116	206	10	206		206	24
25	Universal shower panel - wall-mounted shower system			1999	1,963	196	10	196		327	25
26	Install & program 3 telephones			2000	1,537	77	10	77		77	26
27	Furnish 2 stainless steel sinks			2000	4,268	213	10	213		213	27
28	Install 2 stainless steel sinks			2000	2,550	128	10	128		128	28
29	Automatic door operating equipment			2000	16,743	837	10	837		837	29
30											30
31											31
32	Allocated from Management Company-See Attached Detailed Schedule				1,210						32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 7,392		$ 7,392	$	$ 10,764	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,600,440	$ 160,045	$ 160,045	$	10 years	$ 1,028,815	37
38	Current Year Purchases	87,591	4,378	4,378		10 years	4,378	38
39	Fully Depreciated Assets	157,076	445	445		8,9,10 years	157,076	39
40	Allocated from Mgt Comp:	183,998		16,365	16,365		66,545	40
41	TOTALS	$ 2,029,105	$ 164,868	$ 181,233	$ 16,365		$ 1,256,814	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Maintenance	1976 Pick-up Truck	1993	$ 3,303	$ 0	$ 0	$	5 years	$ 3,303	42
43										43
44	Allocated from Management Company:			16,206		3,095	3,095	5 years	12,662	44
45										45
46	TOTALS			$ 19,509	$	$ 3,095	$ 3,095		$ 15,965	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 233,585	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 372,638	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 139,053	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,483,359	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Parking Lot				3,000	month to month		6
7	TOTAL				$ 3,000 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: ☐ YES ☒ X NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 22,764 Description: Copier $7,920, Ice-maker $1,972, Postage meter $396, Medical equipment $10,232, Mgt Co alloctn. $2,244
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	1997 Mitsubishi	$ 393.00	$ 3,936	17
18	Administrative	1996 Caravan	530.00	5,300	18
19					19
20	Allocated from Management Company:			8,483	20
21	TOTAL		$ 923.00	$ 17,719	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		2,654		2,654
9	TOTALS	$	$ 2,654	$	$ 2,654
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,654			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 0

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	29
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	29

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	Ln10a,Col 2&3	hrs	$	1,534	$ 62,883	$ 195	1,534	$ 63,078	1
2	Licensed Speech and Language Development Therapist	Ln 10a, Col 3	hrs		91	3,732		91	3,732	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln10a,Col 2&3	hrs		214	100,081	602	214	100,683	4
5	Physician Care	Ln 39, Col 3	visits			852			852	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Ln 39, Col 2	# of prescrpts				126,213		126,213	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	Ln 39,Col 2,5					26,464		26,464	12
13	Other (specify): Respiratory Therapy	Ln 39, Col 3 Ln 10a, Col 3			10	12,682 310		10	12,624 310	13
14	TOTAL			$	1,849	$ 180,540	$ 153,474	1,849	$ 333,956	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,526,073	$ 6,474,747	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 184,000)	2,324,723	2,324,723	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	159,408	159,408	6
7	Other Prepaid Expenses	805,690	805,690	7
8	Accounts Receivable (owners or related parties)	168,570	168,570	8
9	Other(specify): Other Receivables	50,025	50,226	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,034,489	$ 9,983,364	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		548,682	13
14	Buildings, at Historical Cost		4,689,797	14
15	Leasehold Improvements, at Historical Cost	879,706	993,048	15
16	Equipment, at Historical Cost	739,651	2,048,614	16
17	Accumulated Depreciation (book methods)	(788,583)	(2,483,359)	17
18	Deferred Charges		60,739	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	273,985	273,985	22
23	Other(specify): Mortgage Costs (Net)		135,141	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,104,759	$ 6,266,647	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,139,248	$ 16,250,011	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 181,399	$ 290,287	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	129,373	129,373	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	176,889	176,889	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,160	5,160	31
32	Accrued Real Estate Taxes(Sch.IX-B)		367,000	32
33	Accrued Interest Payable		(4,283)	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule E:	1,493,199	1,493,199	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,986,020	$ 2,457,625	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,500,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 6,500,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,986,020	$ 8,957,625	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,153,228	$ 7,292,386	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,139,248	$ 16,250,011	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Print Preview

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 7,000,741	1
2	Restatements (describe):		2
3	**Prior Period Adjustments:**	621,128	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 7,621,869	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	881,359	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,350,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (468,641)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 7,153,228	24 *

* Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,738,648	1
2	Discounts and Allowances for all Levels	(1,360,650)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,377,998	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	422,329	6
7	Oxygen	119,114	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 541,443	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	174,286	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	120,362	19
20	Radiology and X-Ray	2,343	20
21	Other Medical Services	309,181	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 606,172	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	312,618	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 312,618	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,838,231	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 2,045,909	31
32	Health Care	3,849,623	32
33	General Administration	3,011,517	33
	B. Capital Expense		
34	Ownership	2,429,676	34
	C. Ancillary Expense		
35	Special Cost Centers	449,327	35
36	Provider Participation Fee	170,820	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,956,872	40
41	**Income before Income Taxes (line 30 minus line 40)****	881,359	41
42	**Income Taxes**	0	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 881,359	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Print Preview

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,252	2,506	$ 81,311	$ 32.45	1
2	Assistant Director of Nursing	3,991	4,268	94,793	22.21	2
3	Registered Nurses	43,770	47,060	1,013,451	21.54	3
4	Licensed Practical Nurses	20,616	21,830	360,206	16.50	4
5	Nurse Aides & Orderlies	131,647	139,425	1,084,642	7.78	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,723	2,141	22,440	10.48	8
9	Activity Director	2,050	2,249	31,697	14.09	9
10	Activity Assistants	14,657	15,901	109,944	6.91	10
11	Social Service Workers	4,480	4,672	52,041	11.14	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,745	2,983	29,549	9.91	14
15	Cook Helpers/Assistants	36,454	39,773	310,336	7.80	15
16	Dishwashers					16
17	Maintenance Workers	8,145	8,915	111,665	12.53	17
18	Housekeepers	36,742	39,184	265,634	6.78	18
19	Laundry	14,073	15,332	110,592	7.21	19
20	Administrator	2,043	2,238	82,144	36.70	20
21	Assistant Administrator	3,143	3,294	70,741	21.48	21
22	Other Administrative	1,612	1,612	71,899	44.60	22
23	Office Manager					23
24	Clerical	9,570	9,720	395,672	40.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,175	4,489	43,215	9.63	31
32	Other Health Care(specify)					32
33	Other(specify) Ward Clerk	14,480	15,442	167,428	10.84	33
34	TOTAL (lines 1 - 33)	358,368	383,034	$ 4,509,400 *	$ 11.77	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 35,360	Ln 1,Col 3	35
36	Medical Director	Monthly	44,000	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,500	Ln 10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	28	1,221	Ln 11, Col 3	44
45	Social Service Consultant	71	3,348	Ln 12, Col 3	45
46	Other(specify)				46
47	Religious Consultant	Monthly	405	Ln 12, Col 3	47
48	Medical Librarian	26	1,430	Ln 10, Col 3	48
49	TOTAL (lines 35 - 48)	125	$ 87,264		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,824	$ 85,983	Ln 10, Col 3	50
51	Licensed Practical Nurses	4,025	116,091	Ln 10, Col 3	51
52	Nurse Aides	63	754	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	6,912	$ 202,828		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sidney Glenner	Administrative	80.00%	$ 31,185
Barry Ray	Administrative	20.00%	23,389
David Glenner	Administrative	0.00%	17,325
Joshua Ray	Administrator	0.00%	82,144
Rae Lyons	Asst. Administrator	0.00%	23,474
Evelyn Mercado	Asst. Administrator	0.00%	47,267
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 224,784

B. Administrative - Other

Description	Amount
Management Fees (eliminated in Column 7)	$ 1,386,711
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,386,711

C. Professional Services

Vendor/Payee	Type	Amount
Health Data Systems	Computers	$ 6,865
American Express/Frost,Ruttenberg	Accounting	46,102
Sachnoff &Weaver/L.Mendelson	Legal	11,637
Burke, Warren & Mackay	Legal	1,148
Schiller, Klein & McElroy	Legal	9,837
Davidson Consulting/Gloria Kas	Inservice Nurses Evaluation	1,200
Howard Chez/Moshe Calamaro	Maintenance Engineering	1,194
James O. Hamilton	Real Estate Appraisal	4,000
SAS Architects/Architects&Planner	Architectural Services	2,293
Gabriel Laboratories	Environmental Consulting	1,280
Personnel Planners	Unemployment Consulting	3,095
Commitment Consulting	A/R Collections	24,252
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 112,903

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 57,932
Unemployment Compensation Insurance	24,623
FICA Taxes	308,234
Employee Health Insurance	65,373
Employee Meals	30,928
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	9,648
Union Health and Welfare	75,567
Union Pension Fund	37,138
Profit Sharing Plan, 401K Match	37,846
Employee Appreciation, Gifts, Bonuses, Awards	8,708
Employee Vaccinations,Medical Reimbursement	5,040
Allocated from Management Company:	60,999
TOTAL (agree to Schedule V, line 22, col.8)	$ 722,036

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	13,658
Health Care Worker Background Check	
(Indicate # of checks performed 131)	917
City of Chicago Business License	1,000
City of Chicago Driveway Usage Permit	704
Illinois Council on Long Term Care Dues	7,979
Miscellaneous Dues, Fees & Subscriptions	870
Allocated from Management Company:	1,978
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,106

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	0
Seminar Expense	0
Allocated from Management Company:	1,781
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,781

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting & Decorating	1996	$ 98,065	3 years	$ 32,688	$ 32,688	$ 16,345	$	$	$	$	$	$
2	Repairs & Maintenanc	1997	4,047	3 years	675	1,349	1,349	674					
3	Painting & Decorating	1997	37,211	3 years	6,202	12,404	12,404	6,201					
4	Painting & Decorating	1998	9,975	3 years		1,662	3,325	3,325	1,663				
5	Repairs & Maintenanc	1998	1,594	3 years		266	531	531	266				
6	Painting & Decorating	1999	88,181	3 years			14,697	29,394	29,394	14,696			
7	Painting & Decorating	2000	17,664	3 years				2,944	5,888	5,888	2,944		
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 256,737		$ 39,565	$ 48,369	$ 48,651	$ 43,069	$ 37,211	$ 20,584	$ 2,944	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glencrest Nursing Rehabilitation Center # 0028753 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care $7,979**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **36,914** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **170,820**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **30,928** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Print Preview